



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF SOUTHWEST FORT WORTH
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Carrier's Austin Representative Box

Box Number 19

Respondent Name

MIDDLESEX INSURANCE CO

MFDR Date Received

March 21, 2012

MFDR Tracking Number

M4-12-2440-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of SW Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008. Per the applicable Texas fee schedule the correct allowable would be per the DRG 301. The allowable for this DRG per Medicare is \$12,796.51, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at \$18,299.00. Based on their payment of \$5,419.87, there is an additional of \$12,879.14, still due at this time."

Amount in Dispute: \$12,879.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is whether the pass thru amount noted in the Medicare Inpatient Hospital Pricer is to be included in the Medicare Inpatient Prospective Payment System reimbursement formula for this inpatient hospital stay. The bill reviews performed by us vary from the amount shown on the CMS website Prospective Payment System (PPS) Inpatient PCPricer because the amount provided by PCPricer includes what is commonly referred to as the 'pass throughs'. The pass through amount is an estimate of Medicare bad debts, organ acquisition costs, and graduate medical education expenses for those hospitals that want to project the impact of these expenses on their total income for the year. The pass through costs in the PCPricer system represent Medicare patient costs, not costs associated with a workers' compensation claim. Therefore, no additional allowance is due. In addition, because we cannot control or confirm that the IPPS impact file that Medicare publishes is accurately coded within the IPPS PC Pricer software, the PC pricer shouldn't be used for acute IPPS as it relates to workers' compensation claim."

Response Submitted by: Sentry Insurance, P. O. Box 8032, Stevens Point, WI 54481

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2011 To October 19, 2011	Inpatient Hospital Surgical Services	\$12,879.14	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
 - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 18, 2011

 - 1 – (45) – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

Issues

1. Will the Division address the new issue raised by the respondent in their response to this dispute?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent asserts in their response that at issue is whether the pass thru amount noted in the Medicare Inpatient Hospital Pricer is to be included in the Medicare Inpatient Prospective Payment System reimbursement formula for this inpatient hospital stay. The respondent further asserts that the PC Pricer shouldn't be used for acute IPPS as it relates to workers' compensation claim. Per 28 Texas Administrative Code §133.307(d)(2)(B), "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Per 28 Texas Administrative Code §133.307(d)(2)(B), this new issue will not be further addressed in this dispute review.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 301 is \$3,770.09. This amount multiplied by 143% is \$5,391.23. The total maximum allowable reimbursement (MAR) is therefore \$5,391.23. The respondent previously paid \$5,419.87, therefore an additional amount of \$0.00 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	June 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.